

NOTICE OF TERMINATION OF LIABILITY

Michigan Department of Labor & Economic Growth
 Workers' Compensation Agency
 P.O. Box 30016, Lansing, Michigan 48909

INSTRUCTIONS: SEE REVERSE SIDE

1. Employer Federal ID Number					
2. Name of Business(es)					
3. Owner of Business (if applicable)					
4. Business Address (Street Number and Name)		City	State		
4. Business Address (Street Number and Name)		City	State		
5. NAIC Carrier ID Number (9 digits)	6. ZIP Code of Issuing Office	7. Name of Insurance Company			
8. Policy Number		9. Effective Date of Termination			
<p>10. The policy is cancelled and all business names and addresses operating under the Federal ID Number listed in Item #1 are terminated for the following reason:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 40%; vertical-align: top;"> <ul style="list-style-type: none"> A. Non-payment of premium B. Employer insuring elsewhere C. Employer no longer in business D. Employer uncooperative E. Other (provide reason) _____ </td> <td style="width: 60%; text-align: center; vertical-align: middle;"> <p>Failure to maintain required insurance may subject the employer to a fine of \$1,000 per day and imprisonment up to six months.</p> </td> </tr> </table>				<ul style="list-style-type: none"> A. Non-payment of premium B. Employer insuring elsewhere C. Employer no longer in business D. Employer uncooperative E. Other (provide reason) _____ 	<p>Failure to maintain required insurance may subject the employer to a fine of \$1,000 per day and imprisonment up to six months.</p>
<ul style="list-style-type: none"> A. Non-payment of premium B. Employer insuring elsewhere C. Employer no longer in business D. Employer uncooperative E. Other (provide reason) _____ 	<p>Failure to maintain required insurance may subject the employer to a fine of \$1,000 per day and imprisonment up to six months.</p>				

Pursuant to the Workers' Disability Compensation Act, this is to certify that the insurance company carrying the workers' compensation insurance on the above referenced employer has terminated its liability as indicated.

11. Authorized Signature	Date
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<p>The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.</p>	<p>Authority: Workers' Disability Compensation Act of 1969, 418.621(4)(g); R408.41a Completion: Mandatory Penalty: Failure to file is punishable under MCLA 418.631</p>
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Purpose of Form WC-401:

To notify the Michigan Workers' Compensation Agency of the termination of a policy issued to an employer.

A separate WC-401 should be filed for each Federal ID number being cancelled in the policy.

When Required:

- Must be filed with the agency at least 20 days prior to the effective date of termination.
- Only one copy should be filed with the agency.
- A copy must be mailed to the employer.
- Must be used to terminate all coverage for the employer.

INSTRUCTIONS FOR COMPLETION

Item #1 – Employer Federal Identification Number

Enter the employer Federal Identification Number or Social Security Number shown on the Form WC-400. This number is **required** on all Form WC-401 filings.

Item #2 – Name of Business

Enter the name(s) of the business(es) which are to be cancelled from the policy. If all names and addresses of the business are to be cancelled, list only the primary employer name and address, the owner name, and complete item #10.

Item #3 – Owner of Business

List the complete name of the corporation, partnership, individual, joint venture, or public employer which owns the business. If item #2 is identical to item #3, leave item #3 blank.

Item #4 – Business Address

List the main address of the business to be cancelled (including city, state and ZIP code).

Item #5 – NAIC Carrier ID Number (9 digits)

National Association of Insurance Commissioners (NAIC) ID number (5 digits) followed by the group number (4 digits) of the insurance company.

Item #6 – ZIP Code of Issuing Office

Enter the complete ZIP code for the insurance carrier office issuing the form. This ZIP code number will be used on all correspondence sent by the agency to the designated contact person for each carrier.

Item #7 – Name of Insurance Company

The full name of the insurance company.

Item #8 – Policy Number

Enter complete policy number. Maximum 20 digits.

Item #9 – Effective Date of Termination

Intended date of termination. Numeric (Month/Day/Year).

Item #10 – Policy Cancelled and Reason for Termination

Complete only if all business names, divisions and addresses are to be terminated. Check only one reason for termination.

Check **A** if policy is cancelled for non-payment of premium.

Check **B** if employer is insuring elsewhere.

Check **C** if entire employer operating under this Federal ID Number is out of business.

Check **D** if policy is cancelled due to employer being uncooperative.

Check **E** if termination is for any other reason. Please note the reason.

Item #11 – Authorized Signature

Must have an original signature in black or blue ink. Typed signatures are not acceptable. Include the date the form was signed.